

**FOX ARMY HEALTH CENTER  
OCCUPATIONAL MEDICINE**

**OSHA Respirator Medical Evaluation Questionnaire  
(Mandatory)**

**To the employer:** Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

**To the employee:**

Can you read? (select one):

Yes ☐ No ☐

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

**Part A. Section 1. (Mandatory)** The following information must be provided by every employee who has been selected to use any type of respirator (please print). Today's date \_\_\_\_\_

Name \_\_\_\_\_

Job Title \_\_\_\_\_

Age \_\_\_\_\_

Male/ Female  
(circle one)

Height (ft, in) \_\_\_\_\_

Weight (lbs) \_\_\_\_\_

A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code):  
\_\_\_\_\_

The best time to phone you at this number:  
\_\_\_\_\_

Has your employer told you how to contact the health care professional who will review this questionnaire (select one):

Yes ☐ No ☐

Check the type of respirator you will use (you can check more than one category):

a. \_\_\_\_\_ N, R, or P disposable respirator (filter-mask, non-cartridge type only).

b. \_\_\_\_\_ Other type

☐ half- face

☐ full-facepiece type,

☐ powered-air purifying,

☐ supplied-air,

☐ self-contained breathing apparatus.

Have you worn a respirator (select one):

Yes ☐ No ☐

If "yes," what type(s): \_\_\_\_\_

**Part A. Section 2. (Mandatory)** Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please select "yes" or "no").

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month Yes ☐ No ☐

## OSHA Respiratory Questionnaire

### 2. Have you ever had any of the following conditions?

Seizures (fits)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes (sugar disease)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Allergic reactions that interfere with your breathing	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Claustrophobia (fear of closed-in places)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Trouble smelling odors	Yes <input type="checkbox"/>	No <input type="checkbox"/>

### 3. Have you ever had any of the following pulmonary or lung problems?

Asbestosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Chronic bronchitis:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Emphysema:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pneumonia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Silicosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pneumothorax (collapsed lung)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Lung cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Broken ribs:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Any chest injuries or surgeries:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Any other lung problem that you've been told about:	Yes <input type="checkbox"/>	No <input type="checkbox"/>

### 4. Do you currently have any of the following symptoms of pulmonary or lung illness?

Shortness of breath:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Shortness of breath when walking fast on level ground or walking up a slight hill or incline	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Shortness of breath when walking with other people at an ordinary pace on level ground:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have to stop for breath when walking at your own pace on level ground:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Shortness of breath when washing or dressing yourself:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Shortness of breath that interferes with your job:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Coughing that produces phlegm (thick sputum):	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Coughing that wakes you early in the morning:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Coughing that occurs mostly when you are lying down:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Coughing up blood in the last month:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Wheezing:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Wheezing that interferes with your job:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Chest pain when you breathe deeply:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Any other symptoms that you think may be related to lung	Yes <input type="checkbox"/>	No <input type="checkbox"/>

### 5. Have you ever had any of the following cardiovascular or heart problems?

Heart attack	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Stroke:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Angina:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart failure:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Swelling in your legs or feet (not caused by walking):	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart arrhythmia (heart beating irregularly):	Yes <input type="checkbox"/>	No <input type="checkbox"/>
High blood pressure:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Any other heart problem that you've been told about:	Yes <input type="checkbox"/>	No <input type="checkbox"/>

### 6. Have you ever had any of the following cardiovascular or heart symptoms?

Frequent pain or tightness in your chest	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pain or tightness in your chest during physical activity	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pain or tightness in your chest that interferes with your job	Yes <input type="checkbox"/>	No <input type="checkbox"/>
In the past two years, have you noticed your heart skipping or missing a beat :	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heartburn or symptoms that is not related to eating	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Any other symptoms that you think may be related to heart or circulation problems:	Yes <input type="checkbox"/>	No <input type="checkbox"/>

## OSHA Respiratory Questionnaire

**7. Do you currently take medication for any of the following problems:**

Breathing or lung problems:

Yes ☐ No ☐

Heart trouble:

Yes ☐ No ☐

Blood pressure:

Yes ☐ No ☐

Seizures (fits):

Yes ☐ No ☐

**8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check the following space and go to question 9)**

Eye irritation:

Yes ☐ No ☐

Skin allergies or rashes:

Yes ☐ No ☐

Anxiety:

Yes ☐ No ☐

General weakness or fatigue:

Yes ☐ No ☐

Any other problem that interferes with your use of a respirator:

Yes ☐ No ☐

**9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire:**

Yes ☐ No ☐

Questions 10-15 below must be answered by every employee who has been selected to use a *full-facepiece* respirator or a *self-contained breathing apparatus (SCBA)*. For employee have been selected to use other types of respirators, answering these questions is voluntary

**10. Have you ever lost vision in either eye (temporarily or permanently):**

Yes ☐ No ☐

**11. Do you currently have any of the following vision problems?**

Wear contact lenses:

Yes ☐ No ☐

Wear glasses:

Yes ☐ No ☐

Color blind:

Yes ☐ No ☐

Any other eye or vision problem:

Yes ☐ No ☐

**12. Have you ever had an injury to your ears, including a broken ear drum:**

Yes ☐ No ☐

**13. Do you currently have any of the following hearing problems?**

Difficulty hearing:

Yes ☐ No ☐

Wear a hearing aid:

Yes ☐ No ☐

Any other hearing or ear problem:

Yes ☐ No ☐

**14. Have you ever had a back injury:**

Yes ☐ No ☐

**15. Do you currently have any of the following musculoskeletal problems?**

Weakness in any of your arms, hands, legs, or feet:

Yes ☐ No ☐

Back pain:

Yes ☐ No ☐

Difficulty fully moving your arms and legs:

Yes ☐ No ☐

Pain or stiffness when you lean forward or backward at the waist:

Yes ☐ No ☐

Difficulty fully moving your head up or down:

Yes ☐ No ☐

Difficulty fully moving your head side to side:

Yes ☐ No ☐

Difficulty bending at your knees:

Yes ☐ No ☐

Difficulty squatting to the ground:

Yes ☐ No ☐

Climbing a flight of stairs or a ladder carrying more than 25 lbs:

Yes ☐ No ☐

Any other muscle or skeletal problem that interferes with using a respirator:

Yes ☐ No ☐

## OSHA Respiratory Questionnaire

**Part B** Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen: Yes ☐ No ☐

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: Yes ☐ No ☐

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: Yes ☐ No ☐

If "yes," name the chemicals if you know them: \_\_\_\_\_

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Have you ever worked with any of the materials, or under any of the conditions, listed below:

**Substance/Conditions**

**Description of exposure (only if answer is yes)**

Asbestos	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Silica (e.g., in sandblasting)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Tungsten/cobalt (e.g., grinding or welding this material)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Beryllium:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Aluminum	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Coal (for example, mining)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Iron:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Tin:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dusty environments:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Any other hazardous exposures:	Yes <input type="checkbox"/>	No <input type="checkbox"/>

4. List any second jobs or side businesses you have: \_\_\_\_\_

5. List your previous occupations: \_\_\_\_\_

6. List your current and previous hobbies: \_\_\_\_\_

7. Have you been in the military services? Yes ☐ No ☐

If "yes," were you exposed to biological or chemical agents (either in training or combat):

Yes ☐ No ☐

8. Have you ever worked on a HAZMAT team? Yes ☐ No ☐

# OSHA Respiratory Questionnaire

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): Yes ☐ No ☐

If "yes," name the medications if you know them: \_\_\_\_\_

10. Will you be using any of the following items with your respirator(s)?

HEPA Filters:

Yes ☐ No ☐

b. Canisters (for example, gas masks):

Yes ☐ No ☐

c. Cartridges:

Yes ☐ No ☐

11. How often are you expected to use the respirator(s) (select "yes" or "no" for all answers that apply to you)?:

a. Escape only (no rescue):

Yes ☐ No ☐

b. Emergency rescue only:

Yes ☐ No ☐

c. Less than 5 hours per week:

Yes ☐ No ☐

d. Less than 2 hours per day:

Yes ☐ No ☐

e. 2 to 4 hours per day:

Yes ☐ No ☐

f. Over 4 hours per day:

Yes ☐ No ☐

12. During the period you are using the respirator(s), is your work effort:

<b>Light</b> (less than 200 kcal per hour): Yes <input type="checkbox"/> No <input type="checkbox"/>	If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.
<i>Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines</i>	
<b>Moderate</b> (200 to 350 kcal per hour): Yes <input type="checkbox"/> No <input type="checkbox"/>	If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.
<i>Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.</i>	
<b>Heavy</b> (above 350 kcal per hour): Yes <input type="checkbox"/> No <input type="checkbox"/>	If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.
<i>Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).</i>	

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: Yes ☐ No ☐

If "yes," describe this protective clothing and/or equipment: \_\_\_\_\_

14. Will you be working under hot conditions (temperature exceeding 77 deg. F): Yes ☐ No ☐

## OSHA Respiratory Questionnaire

15. Will you be working under humid conditions:

Yes ☐ No ☐

16. Describe the work you'll be doing while you're using your respirator(s): \_\_\_\_\_

\_\_\_\_\_

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s)  
(for example, confined spaces, life-threatening gases):

\_\_\_\_\_

\_\_\_\_\_

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Name of Toxic Substance	Estimated maximum Exposure level per shift	Duration of exposure per shift

The name of any other toxic substances that you'll be exposed to while using your respirator:

\_\_\_\_\_

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

To the best of my knowledge, the information I have provided is true and accurate.

\_\_\_\_\_  
Employee Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee Signature

Employee name: \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Agency: \_\_\_\_\_ Work location: \_\_\_\_\_ Job title: \_\_\_\_\_  
Supervisor's name: \_\_\_\_\_ Supervisor's phone: \_\_\_\_\_ fax: \_\_\_\_\_  
Type of respirator use requested: \_\_\_ disposable, \_\_\_ negative pressure (cartridge), \_\_\_ PAPR, \_\_\_ airline, \_\_\_ SCBA

I. Basis for recommendations on respirator clearance:

*Recommendations below on medical clearance for respirator use are based on a review of (check all that apply):*

- \_\_\_ Mandatory OSHA Respirator Medical Evaluation Questionnaire  
\_\_\_ Records of a medical examination, including physical exam, done on: \_\_\_\_\_  
\_\_\_ Additional information supplied by employee's personal physician.  
\_\_\_ Other information (specify): \_\_\_\_\_

II. Recommendations on medical clearance for respirator use: (Choose A, B or C below)

- ☐ A. The employee is given medical clearance to use the following respirator(s) under the conditions noted (choose all that apply)

___ N, R or P disposable respirator (filter-mask, non-cartridge type only)	___ Supplied air (air line) respirator
___ Negative pressure air-purifying (cartridge) respirator -- either half- or full-face	___ Self-contained breathing apparatus (SCBA)
___ Powered air purifying respirator (PAPR) -- either half or full face	

*When using respirators, the employee is approved to perform the following (choose one)*

- \_\_\_ Mild exertion /low heat stress  
\_\_\_ Moderate exertion  
\_\_\_ Heavy exertion  
\_\_\_ Escape only  
\_\_\_ Normal job duties  
\_\_\_ Other Activity \_\_\_\_\_

*Mild exertion (2-3 mets) e.g. lifting up to 10 lbs, extended walking on a flat surface, extended standing*

*Moderate exertion (4-5 mets) e.g. lifting 10 lbs, 5 lifts per min, fast walking (4 mph), gardening/digging, pushing, pulling*

*Heavy exertion (5-10 mets) e.g. jogging (10 min/mi), chopping wood, climbing hills, life-saving activities, fire fighting*

*This respirator clearance expires (circle one) 1 2 3 4 5 years from the date below (If not marked, clearance expires in 1 year)*

- ☐ B. The employee is not given medical clearance for respirator use because more information is needed (Specify what is needed to make a decision)

- ☐ 1. A medical examination, including a physical exam\*, is needed to make a decision\*  
\*- Please use the FOH Medical Surveillance Health History and Physical Evaluation forms for this

- ☐ 2. The following additional information is needed for review (specify what):  
\_\_\_\_\_  
\_\_\_\_\_

- ☐ C. The employee is not given medical clearance for respirator use because of the health problems as noted below (choose one below)

- ☐ 1. A temporary health problem (which should be reevaluated in \_\_\_\_\_ months)  
☐ 2. A health problem that appears permanent (routine re-evaluation is not needed)

Examiner / Reviewer Name (Print) \_\_\_\_\_

Phone number for questions \_\_\_\_\_

Examiner / Reviewer Signature \_\_\_\_\_

Date: \_\_\_\_\_